New Jersey Department of Health and Senior Services
PHARMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED (PAAD),
LIFELINE AND SPECIAL BENEFIT PROGRAMS
PO Box 715
Trenton NJ 08625-0715

ELIGIBILITY APPLICATION

Please PRINT clearly and answer all questions. See instructions on last page. Do NOT use this form if you received PAAD benefits within the last two years. Contact PAAD for a renewal application. If you need assistance completing this form, call toll free 1-800-792-9745.

DO NOT SUBMIT ORIGINAL SUPPORTING DOCUMENTS. SEND COPIES, AS ORIGINALS WILL NOT BE RETURNED.
Mail the completed application to the address listed above.

I am applying for: ☐PAAD ☐Lifeline ☐Hearing Aid Assistance

1

Last Name of Applicant	Maiden Name	First Name	MI	Sex	Date of Birth ___ / ___ / ___ (Month/Day/Year)
Last Name of Spouse	Maiden Name	First Name	MI	Sex	Date of Birth ___ / ___ / ___ (Month/Day/Year)

2

Street Address	City	State	Zip Code	County

TWO (2) PROOFS OF RESIDENCY MUST ACCOMPANY THIS APPLICATION.
(If using a post office box, send proof of your street address.)

How long have you lived at this address? *(See instruction #2)*
_____ Years _____ Months

Is this your principal residence?
☐Yes ☐No

3

Applicant's Social Security Number
__ __ __ - __ __ - __ __ __ __

Spouse's Social Security Number
__ __ __ - __ __ - __ __ __ __

Do you have:

a. Medicare A (hospital Insurance): ☐Yes ☐No

b. Medicare B (medical Insurance): ☐Yes ☐No

Medicare Number: _____ _____ / _____ / _____
Part B Effective Date

Please enclose a copy of your Medicare card(s).

4

To be eligible, you must be age 65 or older or receive Social Security disability benefits.

a. Are you 65 years of age or older? ☐No ☐Yes - If yes, submit proof of age.

b. Are you under age 65 and over age 18 and do you receive Social Security Disability? ☐No ☐Yes - If yes, submit proof of disability.

Documents must accompany this application. See instruction #4.

Did you ever have a PAAD Card?
☐Yes ☐No

If Yes, do you have an outstanding balance for incorrectly paid benefits?
☐Yes ☐No

5

Did you and/or your spouse file a federal, state or city income tax return last year?
☐Yes ☐No

If yes, you must submit signed copies of each return, including all schedules, with this application.

6

Marital Status
☐Single ☐Divorced ☐Separated
☐Married ☐Widowed

Has your marital status changed in the last year?
☐Yes - Date: _____ / _____ / _____
☐No

7 List MONTHLY amount of most recently received Social Security check:

Applicant Alone	Spouse Alone	Joint (Applicant and Spouse)
$ _____	$ _____	$ _____

8 **Sources of Income**

List all income received for the previous calendar year, as well as all income anticipated for the current calendar year. Section A is for actual income (previous year). Section B is for anticipated income (current year). SEE INSTRUCTION #8. DO NOT LEAVE ANY BLANKS. If you receive None, write "O" in the appropriate space. Please be sure to total each column. Do not list cents.

All Sources of Income List Yearly Amounts (If more space is required, attach an additional sheet.)	**Section A Income Previous Year 20____ (Actual)**		**Section B Income Current Year 20____ (Anticipated)**		**For Office Use Only (DO *NOT* WRITE BELOW)**	
	(1) Applicant	**(2) Spouse**	**(1) Applicant**	**(2) Spouse**	**A**	**S**
a. Social Security Benefits (Net)						
b. Medicare Part B Premium *(See Instruction #8)*						
c. Pension Benefits (Gross)						
d. Salary Before Payroll Deductions						
e. Unemployment Benefits						
f. Interest and Dividends, Including Tax Exempt						
g. Rental Income (Net After Expenses)						
h. All Other (Identify)						
TOTAL ANNUAL INCOME (BY COLUMN)						

9 Do you or your spouse receive a pension or salary?

☐Yes ☐No

If Yes, please identify the company, employer, or union:

_____
Name of Company, Employer or Union

_____ ( )
Address Telephone No.

10 If you currently have health insurance coverage with any insurance company, complete this section.

A copy of the front and back of your health insurance card(s) must be attached to this form.

If you and/or your spouse, if married, are enrolled in a Medicare Approved Drug Discount card, you must send copies of the front and back of the card. See Instruction #10 on last page.

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Are you a member of a Medicare HMO?

☐Yes ☐No If Yes, list name: _____

Do you have health coverage in addition to Medicare?

☐Yes ☐No **If Yes, you must submit a copy of the FRONT AND BACK of your health insurance card(s).**

_____ _____
Name of Insurance Company Telephone Number

_____
Address

Does this insurance cover prescriptions? What is the deductible? What is the co-pay?

☐Yes ☐No $ _____ $ _____

Is this coverage through the pension/salary listed in Question 9?

☐Yes ☐No If from different company, employer or union, please identify below:

_____
Name of Employer or Union

_____
Address

11

Hearing Aid Assistance to the Aged and Disabled

PAAD eligibles who purchase a hearing aid may receive a $100 payment to offset the cost of purchase. If you would like to apply for Hearing Aid Assistance to the Aged and Disabled, please submit the following with this application:

1. a physician's prescription or letter attesting to the medical necessity for obtaining a hearing aid and
2. a receipt for the recent purchase of the hearing aid.

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Lifeline Utility Benefits (SSI Beneficiaries should *not* apply; the Lifeline utility benefit is already included in monthly SSI checks)

A. LIFELINE CREDIT PROGRAM:
If you are a utility customer, submit a copy of your most recent electric and/or gas statement/bill.

1. Name of Electric Co. _____
2. Name of Gas Co. _____
3. Name on Bill _____
4. Relationship to Applicant _____

B. TENANT'S LIFELINE ASSISTANCE PROGRAM:
If you are a tenant and the cost of electric/gas is included in your rent, complete the following:

1. Name of Landlord _____
2. Address of Landlord _____
3. Check the box which most accurately describes your principal place of residence.

☐ Rent House ☐ Condominium ☐ Apartment ☐ Boarding Home
☐ Own House ☐ Trailer Park ☐ Other, specify: _____

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N/C: _____ C/C: _____ S/C: _____ Category Code: _____

Electric: _____-_____ Gas: _____-_____

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A. I/we certify that the information above is true and accurate to the best of my/our knowledge and that I/we meet all Programs eligibility requirements.

B. I/we will return my/our eligibility card(s) immediately if my/our income rises above the legal limits, or if I/we move from New Jersey, or if I/we become New Jersey Care or Medicaid eligible. If I/we are determined eligible based on my/our disability(ies), I/we will return my/our eligibility card(s) if I/we stop receiving Social Security Disability Benefits.

C. I/we authorize the release of information necessary to determine my/our eligibility from the records in possession of the Social Security Administration, Internal Revenue Service, the New Jersey Division of Taxation, Division of Medical Assistance and Health Services, employers, banks, utility companies and others as the need arises. I/we authorize my/our physician(s) to release information concerning prescriptions which have been paid on my/our behalf by the Programs.

D. I/we understand that I/we may be visited by representatives of the Department of Health and Senior Services in order to verify my/our eligibility for benefits and determine availability of other prescription coverage and I/we authorize such visitations.

E. I/we hereby assign the State of New Jersey as my/our authorized representative, any right to drug benefits to which I/we may be entitled under any other plan of assistance or insurance, from any other liable third party or drug benefits under any other plan of governmental assistance.

F. I/we understand that the Department of Health and Senior Services is entitled to full repayment for incorrectly provided benefits. I/WE FURTHER UNDERSTAND THAT IF I/WE LOSE ELIGIBILITY BECAUSE OF AN INCREASE IN ANNUAL INCOME, I/WE ARE LIABLE FOR REPAYMENT OF ALL MONIES PAID ON MY/OUR BEHALF BY THE STATE OF NEW JERSEY FROM THE BEGINNING OF THE CALENDAR YEAR, NOT JUST THOSE PAYMENTS MADE AFTER MY/OUR INCOME INCREASED AND EXCEEDED THE ELIGIBILITY LIMITS, AND THAT FAILURE TO REPAY BENEFITS INCORRECTLY PROVIDE ON MY/OUR BEHALF IS CONSIDERED A VIOLATION OF STATE LAW AND WILL SUBJECT ME/US TO SUSPENSION OF BENEFITS IN THE FUTURE.

G. I/we understand that the use of my/our eligibility card(s) and the receipt of benefits in any calendar year certifies and confirms my/our agreement to accept full liability for repayment of all benefits incorrectly received in that year.

Signature or Mark of Applicant	Telephone Number ( )
Signature or Mark of Spouse (If Married)	Date
Person to Contact if Questions Arise	Telephone Number ( )
Signature of Preparer	Date

INSTRUCTIONS FOR COMPLETING ELIGIBILITY APPLICATION

Please note that each person MUST file an individual PAAD application, even though joint income (of applicant and spouse) is considered in determining eligibility.

The following instructions are numerically keyed to the various sections of the form.

SECTION 2

Enter your principal place of residence. Two proofs of residence must accompany the application. The proofs must be current and dated. The date must be clearly visible and be within the last six months.

Some examples of sources of evidence of residency are:

- Public utility records and receipts (e.g. telephone bill, electric bill, etc.)
- Employment records
- Motor Vehicle Records (e.g. valid Driver's License)
- Social Security Form #2458 or Third Party Query Form
- Personal property assessment records
- Bills of business or professional people (e.g. doctors, department stores, etc.)
- Post Office records
- Records of social agencies, public or private

Note: Seasonal or temporary residence in New Jersey, of whatever duration, does NOT constitute residence.
The residency requirement states that you must be a resident of New Jersey for at least 30 days prior to the date of the application.

SECTION 3

You are not required to submit your Social Security number, however, failure to provide one will delay the processing of your application. Your Social Security number will be used to create a unique identifier to track your application, to provide and record pharmaceutical benefits, to verify eligibility by matching tax files at the New Jersey Division of Taxation, and to identify other prescription coverage by searching health insurance records.

Indicate whether you have Medicare. Enter your Medicare number(s) and the effective date of the Part B coverage, and enclose a COPY of your Medicare card(s).

SECTION 4

a) If you are age 65 or older, submit a ***COPY*** of one of the following documents:

- Birth Certificate
- Baptismal Certificate
- Any Social Security record which indicates your age
- Railroad Retirement record which indicates your age

IF YOU CANNOT SUPPLY A COPY OF ONE OF THE ABOVE DOCUMENTS, ***COPIES*** OF ANY ***TWO*** OF THE FOLLOWING DOCUMENTS WHICH INDICATE AGE WILL BE ACCEPTABLE:

- Driver's License
- Foreign Passport
- State or Federal Census record
- Delayed Birth Certificate
- Insurance Policy
- Marriage Record
- Voting Record
- School Record

b) If you are UNDER 65 years of age and over 18 years of age and receive Social Security Title II Disability Benefits, submit a ***COPY*** of one of the following documents:

- Social Security Award Certification (SSA-L30) issued by the Social Security Administration within the last six months
- Verification of your disability status by your local Social Security Office through the "Report of Confidential Social Security Beneficiary Information" (SSA-2458) or Third Party Query Form which indicates your current Social Security Disability status.

SECTION 7

Indicate the exact amount of the most recently received Social Security check(s). If separate checks are received, list your and your spouse's checks separately. If a joint check is received, indicate total amount.

SECTION 8

Jointly earned income should be allocated according to your and your spouse's share of ownership.

*The annual Medicare Part B premium must be included as income on Line b of Question 8 if you and/or your spouse have this premium deducted monthly from your Social Security check. NOTE: The monthly deduction should be multiplied by twelve (12) to get the yearly amount. Most individuals who receive Disability payments or who are over age 65 have Medicare Part B deducted form their Social Security check.

Examples of other income which must be included under "ALL OTHER" income (Line h) are:

- Gross IRA (including Roth distributions)
- Gross Retirement Benefits/Annuities
- Gross Gambling or Lottery Winnings
- Death Benefits Received (Net)
- Gross Disability Benefits
- Realized Capital Gains
- Royalties
- Inheritance
- Business Income (Net)
- Alimony Payment

As of January 1, 2005, maximum income limits are **less than $20,989 if single; less than $25,735 joint income, if married**. If your income exceeds these limits, you can apply for the Senior Gold Prescription Discount Program, a New Jersey program which assists with the cost of prescription drugs. Call toll free 1-800-792-9745 for more information.

SECTION 10

If you have any health insurance coverage, complete Section 10 and submit a copy of the front and back of your health insurance card(s). **Failure to provide this information will result in the delayed processing of your application.**

SECTION 12

Only one Lifeline benefit will be issued per household. Your Lifeline benefit will be issued approximately 8 to 12 weeks after the effective date of your new PAAD card(s).

SECTION 13

The Certification and Authorization must be dated and signed (or marked) by you, your spouse (if married) and the preparer of the form (if other than the applicant). Anyone other than the applicant who prepares the form must provide his/her name and telephone number, in case questions should arise concerning the application.